

OMB CONTROL NUMBER: 0720-0055
OMB EXPIRATION DATE: XX/XX/XXXX

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected; 1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment Facility

ROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at:

<http://dpcl.d.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx>. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

Please correct the errors and try again.

- Either Sponsor SSN or Sponsor DoD ID is required.

Patient Information

1. Patient Name (last, first, middle initial)			2. SSN or DoD ID		3. DOB (MM/DD/YYYY)
MONGOOSE45	SEAN660	S	XXX-XX-5302	or	11/16/1984
4a. Address			b. Home Telephone Number		
			4445551212		
City	BIRMINGHAM	State	ALABAMA	5a. Family Member Prefix	b. Sponsor SSN or DoD ID
Country		Zip	68123	20	<input type="text"/> or <input type="text"/>
Patient Category	USN RET LOS ENLISTED		Email		
Patient IEN	147258415		<input type="text"/>		
6a. Patient Employer Name			b. Employer Telephone Number		
<input type="text"/>			<input type="text"/>		
<input type="button" value="Next"/>		<input type="button" value="Last"/>		<input type="button" value="Save"/>	
				<input type="button" value="Cancel"/>	



8. Primary Medical Insurance Information: If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below.

a. Name of Policy Holder (last, first, middle initial)

LANG91 LEIGH34 JR

b. DOB (MM/DD/YYYY)

01/02/1992

c. Relationship To Policy Holder

Child

Policy Holder SSN

XXX-XX-7551

Policy Holder Gender

Unknown

d. Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name BALFOUR BEATTY INVESTMENTS

Address

City

State

Country

Zip

Telephone 7775551212

e. Insurance Company Name, Address And Telephone Number

Insurance Company Name BCBS OF FLORIDA

Address PO BOX 1798

City

JACKSONVILLE

State

FLORIDA

Country

Zip

32231

Telephone

8775552273

f. Card Holder ID

g. Policy ID

ABC9046127845

h. Group Policy ID

471505

i. Group Plan Name

ABC CORPORATIO

j. Enrollment/Plan Code

k. Insurance Type (Code, Desc)

GP GROUP POLICY

l. Policy Effective Date (MM/DD/YYYY)

12/17/2013

m. Policy End Date (MM/DD/YYYY)

Policy IEN

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n. (1) Pharmacy (Rc) Insurance Company Name, Address, And Telephone Number

Pharmacy (Rc) Insurance Company Name

ARGUS PHARMACY SERVICES

Address

PO BOX 419019 DEPT 300

City

KANSAS CITY

State

MISSOURI

Country

Zip

64141

Telephone

8885551212

(2) Rx Policy ID

90461278545

(3) Rx BIN Number

600428

(4) Rx PCN Number

03820000

Policy Holder information for pharmacy is the same as medical?

Name of Policy Holder (last, first, middle initial)

LANG91 LEIGH34 JR

DOB (MM/DD/YYYY)

Relationship To Policy Holder

Child

Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name ARGUS

Address

City

State

Country

Zip

Telephone 9995559999

Group Policy ID

0029023

Group Plan Name

ARGUS/ABC

Insurance Type (Code, Desc)

GP GROUP POLICY

Policy Effective Date (MM/DD/YYYY)

01/01/2011

Policy End Date (MM/DD/YYYY)

Policy IEN

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First

Back

Next

Last

Save

Cancel

9. Secondary Medical Insurance Information. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below.

a. Policy Holder Name (last, first, middle initial)	b. DOB (MM/DD/YYYY)	c. Relationship To Policy Holder
<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy Holder SSN	Policy Holder Gender	
<input type="text"/>	<input type="text"/>	

d. Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name

Address

City State Country

Zip Telephone

e. Insurance Company Name, Address And Telephone Number

Insurance Company Name

Address

City State Country

Zip Telephone

Is this secondary coverage Medicare/Medicaid?

a. Yes. (Complete Item 11 in addition to information in Item 9.)

b. No. Item 11 is skipped.

f. Card Holder ID	g. Policy ID	h. Group Policy ID	i. Group Plan Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
j. Enrollment/Plan Code	k. Insurance Type (Code, Desc)	l. Policy Effective Date (MM/DD/YYYY)	m. Policy End Date (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy IEN	<input type="text"/>		
<input type="text"/>			

n. (2) Pharmacy (Rx) Insurance Company Name, Address, And Telephone Number

Pharmacy (Rx) Insurance Company Name

Address

City State Country

Zip Telephone

(2) Rx Policy ID (2) Rx BIN Number (4) Rx PCN Number

Policy Holder information for pharmacy is the same as medical?

Name of Policy Holder (last, first, middle initial) DOB (MM/DD/YYYY) Relationship To Policy Holder

Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name

Address

City State Country

Zip Telephone

Group Policy ID	Group Plan Name	Insurance Type (Code, Desc)	Policy Effective Date (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy End Date (MM/DD/YYYY)	Policy IEN	<input type="text"/>	
<input type="text"/>	<input type="text"/>		

13a. Patient Or Adult Family Member Signature (By signing here I acknowledge that I agree to the pertinent statements in Item 12.)

b. Date (MM/DD/YYYY)

Start Signature Pad

14a. If Patient Refuses To Sign This Form: MTF Representative Signature

b. Date (MM/DD/YYYY)

Start Signature Pad

First

Back

Accept

Print

Save

Cancel